The Patient Health Questionnaire (PHQ-9) - Overview

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression:
- The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.
- The tool rates the frequency of the symptoms which factors into the scoring severity index.
- Question 9 on the PHQ-9 screens for the presence and duration of suicide ideation.
- A follow up, non-scored question on the PHQ-9 screens and assigns weight to the degree to which depressive problems have affected the patient's level of function.

Clinical Utility
The PHQ-9 is brief and useful in clinical practice. The PHQ-9 is completed by the patient in minutes and is rapidly scored by the clinician. The PHQ-9 can also be administered repeatedly, which can reflect improvement or worsening of depression in response to treatment.

Scoring
See PHQ-9 Scoring on next page.

Psychometric Properties
- The diagnostic validity of the PHQ-9 was established in studies involving 8 primary care and 7 obstetrical clinics.
- PHQ scores ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression.
- PHQ-9 scores of 5, 10, 15, and 20 represents mild, moderate, moderately severe and severe depression.¹

¹ Kroenke K, Spitzer R, Williams W. The PHQ-9: Validity of a brief depression severity measure. JGIM, 2001, 16:606-616
The Patient Health Questionnaire (PHQ-9) Scoring

Use of the PHQ-9 to Make a Tentative Depression Diagnosis:
The clinician should rule out physical causes of depression, normal bereavement and a history of a manic/hypomanic episode.

Step 1: Questions 1 and 2
Need one or both of the first two questions endorsed as a “2” or a “3”
(2 = “More than half the days” or 3 = “Nearly every day”)

Step 2: Questions 1 through 9
Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count. (Questions 1-8 must be endorsed as a “2” or a “3” ; Question 9 must be endorsed as “1” a “2” or a “3”)

Step 3: Question 10
This question must be endorsed as “Somewhat difficult” or “Very difficult” or “Extremely difficult”

Use of the PHQ-9 for Treatment Selection and Monitoring

Step 1
A depression diagnosis that warrants treatment or a treatment change, needs at least one of the first two questions endorsed as positive (“more than half the days” or “nearly every day”) in the past two weeks. In addition, the tenth question, about difficulty at work or home or getting along with others should be answered at least “somewhat difficult”

Step 2
Add the total points for each of the columns 2-4 separately
(Column 1 = Several days; Column 2 = More than half the days; Column 3 = Nearly every day. Add the totals for each of the three columns together. This is the Total Score
The Total Score = the Severity Score

Step 3
Review the Severity Score using the following TABLE.

<table>
<thead>
<tr>
<th>PHQ-9 Score</th>
<th>Provisional Diagnosis</th>
<th>Treatment Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-9</td>
<td>Minimal Symptoms*</td>
<td>Support, educate to call if worse, return in one month</td>
</tr>
<tr>
<td>10-14</td>
<td>Minor depression ++</td>
<td>Support, watchful waiting</td>
</tr>
<tr>
<td></td>
<td>Dysthymia*</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td></td>
<td>Major Depression, mild</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>15-19</td>
<td>Major depression, moderately severe</td>
<td>Antidepressant or psychotherapy</td>
</tr>
<tr>
<td>&gt;20</td>
<td>Major Depression, severe</td>
<td>Antidepressant and psychotherapy (especially if not improved on monotherapy)</td>
</tr>
</tbody>
</table>

* If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask “In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?”)

++ If symptoms present ≥ one month or severe functional impairment, consider active treatment
The Patient Health Questionnaire (PHQ-9)

Patient Name ___________________________ Date of Visit _______________________

Over the past 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not At all</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you’re a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Column Totals ______ + ______ + ______
Add Totals Together ______

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

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Date: 03/26/18

INVOICE

Invoice No: 10020161

Ms. Debbie Beard  
Michigan State University  
Statewide Campus System  
A327 East Fee Hall  
East Lansing, MI 48824-1316

Master Reservation No: M021359  
Billing Reference: SCS Cardiology

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<th>Grat.</th>
<th>Charge</th>
<th>After Discount</th>
<th>Qty</th>
<th>Item Charges</th>
</tr>
</thead>
<tbody>
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<td>03/21/18 13:00 - 17:00 Classroom 106</td>
<td>445.00</td>
<td>404.95</td>
<td>1</td>
<td>404.95</td>
<td></td>
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<td>20.0%</td>
<td>17.00</td>
<td>55</td>
<td>935.00</td>
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<tr>
<td>03/21/18 Cookies</td>
<td>20.0%</td>
<td>3.00</td>
<td>6</td>
<td>18.00</td>
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<tr>
<td>03/21/18 Hot Beverage Service</td>
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<td>2.95</td>
<td>40</td>
<td>118.00</td>
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<tr>
<td>03/21/18 Cold Beverage Break</td>
<td>20.0%</td>
<td>2.95</td>
<td>15</td>
<td>44.25</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>03/21/18 Laptop Computer</td>
<td>45.00</td>
<td></td>
<td>1</td>
<td>45.00</td>
<td></td>
</tr>
<tr>
<td>03/21/18 Video / Computer LCD Projector</td>
<td>195.00</td>
<td></td>
<td>1</td>
<td>195.00</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>240.00</strong></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Itemized Charges: 1,800.25  
Less Discounts: 40.05 CR  
Gratuity: 223.05  
Taxed: 0.00  

Invoice Total: 1,983.25

BALANCE DUE: 1,983.25

* Make All Payments Payable To: Michigan State University - Management Education Center  
* Please Return A Copy Of This Invoice With Your Payment To: 811 W. Square Lake Rd. Troy, MI 48098  
* Invoice Terms: Net 30 Days  
* Michigan State University Federal ID: 38-6005984
The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious, or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total Score: \[ \square \] = Add Columns \[ \square + \square + \square \]

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all  | Somewhat difficult  | Very difficult  | Extremely Difficult
---        |---------------------|-----------------|---------------------

Interpreting the Score:

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥10</td>
<td>Possible diagnosis of GAD; confirm by further evaluation</td>
</tr>
<tr>
<td>5</td>
<td>Mild Anxiety</td>
</tr>
<tr>
<td>10</td>
<td>Moderate anxiety</td>
</tr>
<tr>
<td>15</td>
<td>Severe anxiety</td>
</tr>
</tbody>
</table>
Geriatric Depression Scale

The Geriatric Depression Scale (GDS) is a 30-item self-report assessment used to identify depression in the elderly. The scale was first developed in 1982 by J.A. Yesavage and others.\[1\]

Contents

Description
Scale questions and scoring
See also
External links
References

Description

In the Geriatric Depression Scale, questions are answered "yes" or "no." A five-category response set is not utilized in order to ensure that the scale is simple enough to be used when testing ill or moderately cognitively impaired individuals, for whom a more complex set of answers may be confusion, or lead to inaccurate recording of responses.

The GDS is commonly used as a routine part of a comprehensive geriatric assessment. One point is assigned to each answer and the cumulative score is rated on a scoring grid.\[2\] The grid sets a range of 0-9 as "normal", 10-19 as "mildly depressed", and 20-30 as "severely depressed".

A diagnosis of clinical depression should not be based on GDS results alone. Although the test has well-established reliability and validity evaluated against other diagnostic criteria, responses should be considered along with results from a comprehensive diagnostic work-up. A short version of the GDS (GDS-SF) containing 15 questions has been developed,\[3\] and the scale is available in languages other than English. The conducted research found the GDS-SF to be an adequate substitute for the original 30-item scale.\[4\]

The GDS was validated against Hamilton Rating Scale for Depression (HRS-D) and the Zung Self-Rating Depression Scale (SDS). It was found to have a 92% sensitivity and a 89% specificity when evaluated against diagnostic criteria.\[8\]

Scale questions and scoring

The scale consists of 30 yes/no questions. Each question is scored as either 0 or 1 points. The following general cutoff may be used to qualify the severity:
- normal 0-9,
- mild depressives 10-19,
- severe depressives 20-30.

See also

- Diagnostic classification and rating scales used in psychiatry

External links

- Online version of the Geriatric Depression Scale (http://psychology-tools.com/geriatric-depression-scale/)
- Stanford University web site on the Geriatric Depression Scale including translations (http://www.stanford.edu/~yesavage/GDS.html)

References

2. "Geriatric Depression Scale" (http://www.minndisorders.com/Flu-Inv/Geriatric-Depression-Scale.html).


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Geriatric Depression Scale (short form)

Instructions: Circle the answer that best describes how you felt over the past week.

1. Are you basically satisfied with your life? yes no
2. Have you dropped many of your activities and interests? yes no
3. Do you feel that your life is empty? yes no
4. Do you often get bored? yes no
5. Are you in good spirits most of the time? yes no
6. Are you afraid that something bad is going to happen to you? yes no
7. Do you feel happy most of the time? yes no
8. Do you often feel helpless? yes no
9. Do you prefer to stay at home, rather than going out and doing things? yes no
10. Do you feel that you have more problems with memory than most? yes no
11. Do you think it is wonderful to be alive now? yes no
12. Do you feel worthless the way you are now? yes no
13. Do you feel full of energy? yes no
14. Do you feel that your situation is hopeless? yes no
15. Do you think that most people are better off than you are? yes no

Total Score

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The Patient Health Questionnaire-2 (PHQ-2) - Overview

The PHQ-2 inquires about the frequency of depressed mood and anhedonia over the past two weeks. The PHQ-2 includes the first two items of the PHQ-9.

- The purpose of the PHQ-2 is not to establish final a diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach.
- Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder.

Clinical Utility
Reducing depression evaluation to two screening questions enhances routine inquiry about the most prevalent and treatable mental disorder in primary care.

Scoring
A PHQ-2 score ranges from 0-6. The authors identified a PHQ-2 cutoff score of 3 as the optimal cut point for screening purposes and stated that a cut point of 2 would enhance sensitivity, whereas a cut point of 4 would improve specificity.

Psychometric Properties

<table>
<thead>
<tr>
<th>PHQ-2 Score</th>
<th>Major Depressive Disorder (7% prevalence)</th>
<th>Any Depressive Disorder (18% prevalence)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sensitivity</td>
<td>Specificity</td>
</tr>
<tr>
<td>1</td>
<td>97.6</td>
<td>59.2</td>
</tr>
<tr>
<td>2</td>
<td>92.7</td>
<td>73.7</td>
</tr>
<tr>
<td>3</td>
<td>82.9</td>
<td>90.0</td>
</tr>
<tr>
<td>4</td>
<td>73.2</td>
<td>93.3</td>
</tr>
<tr>
<td>5</td>
<td>53.7</td>
<td>96.8</td>
</tr>
<tr>
<td>6</td>
<td>26.8</td>
<td>99.4</td>
</tr>
</tbody>
</table>

* Because the PPV varies with the prevalence of depression, the PPV will be higher in settings with a higher prevalence of depression and lower in settings with a lower prevalence.

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name ___________________________ Date of Visit ___________________

Over the past 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>Not At all</th>
<th>Several Days</th>
<th>More Than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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ASSESSMENT

Timed Up & Go (TUG)

Purpose: To assess mobility

Equipment: A stopwatch

Directions: Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

① Instruct the patient:

When I say “Go,” I want you to:

1. Stand up from the chair.
2. Walk to the line on the floor at your normal pace.
3. Turn.
4. Walk back to the chair at your normal pace.
5. Sit down again.

NOTE: Always stay by the patient for safety.

② On the word “Go,” begin timing.

③ Stop timing after patient sits back down.

④ Record time.

Time in Seconds:

An older adult who takes ≥12 seconds to complete the TUG is at risk for falling.

CDC’s STEADI tools and resources can help you screen, assess, and intervene to reduce your patient’s fall risk. For more information, visit www.cdc.gov/steadi
Instructions for the Mini-Cog Test

Administration
the Mini-Cog test is a 3-minute instrument to screen for cognitive impairment in older adults in the primary care setting. The Mini-Cog uses a three-item recall test for memory and a simply scored clock-drawing test (CDT). The latter serves as an “informative distractor,” helping to clarify scores when the memory recall score is intermediate. The Mini-Cog was as effective as or better than established screening tests in both an epidemiologic survey in a mainstream sample and a multi-ethnic, multilingual population comprising many individuals of low socioeconomic status and education level. In comparative tests, the Mini-Cog was at least twice as fast as the Mini-Mental State Examination. The Mini-Cog is less affected by subject ethnicity, language, and education, and can detect a variety of different dementias. Moreover, the Mini-Cog detects many people with mild cognitive impairment (cognitive impairment too mild to meet diagnostic criteria for dementia).

Scoring (see figure 1)

1 point for each recalled word

Score clock drawing as Normal (the patient places the correct time and the clock appears grossly normal) or Abnormal

Score

- 0  Positive for cognitive impairment
- 1-2  Abnormal CDT then positive for cognitive impairment
- 1-2  Normal CDT then negative for cognitive impairment
- 3  Negative screen for dementia (no need to score CDT)
**Figure 1.** The Mini-Cog scoring algorithm. The Mini-Cog uses a three-item recall test for memory and the intuitive clock-drawing test. The latter serves as an "informative distractor," helping to clarify scores when the memory recall score is intermediate.

Reference
Instructions
Inside the circle draw the hours of a clock as if a child would draw them
Place the hands of the clock to represent the time “forty five minutes past ten o’clock”

Instrucciones
Dentro del círculo dibuje las horas del reloj como si lo haría un niño.
Ponga las manos del reloj para representar el tiempo “cuarenta y cinco minutos después de las diez”
THE MINI-COG

1. Instruct the patient to listen carefully and repeat the following

   APPLE    WATCH    PENNY
   MANZANA  RELOJ   PESETA

2. Administer the Clock Drawing Test

3. Ask the patient to repeat the three words given previously

   _______    _______    _______

Scoring

Number of correct items recalled _______ [if 3 then negative screen. STOP]

If answer is 1-2
   Is CDT Abnormal?  No   Yes

If No, then negative screen
If Yes, then screen positive for cognitive impairment